VERIFICATION OF MENTAL HEALTH TREATMENT SERVICES

Please print in ink or type the requested data

PART I - CHILD INFORMATION

CHILD'S NAME: FIRST	MIDDLE INITIAL	LAST	CHILD'S SOCIAL SECURITY NUMBER:

PART II - MENTAL HEALTH PROFESSIONAL INFORMATION

CLINIC NAME:	MENTAL HEALTH PROFESSIONAL'S NAME:
MENTAL HEALTH PROFESSIONAL'S LICENSE OR REGISTRATION NUMBER:	**LICENSE EXPIRATION DATE:**

Please check your professional level:

☐ Psychiatrist ☐ Psychologist ☐ Licensed Clinical Social Worker

☐ Marriage and Family Therapist ☐ Intern ☐ Other *(Specify)*:_____

Are you providing services under another individual's license number? ☐ **Yes** ☐ **No**

If Yes, please provide the name and license number of the mental health professional:_____

PART III - MENTAL HEALTH SERVICES INFORMATION

DATE(S) OF SERVICE:	TOTAL HOURS OF SERVICE:

TYPE OF SERVICE PROVIDED: ***(CHECK APPLICABLE SERVICES PROVIDED)***

☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy

☐ Psychological Testing ☐ Diagnostic Interview ☐ Medication Evaluation

I certify by my signature that I provided the services listed herein.

MENTAL HEALTH PROFESSIONAL SIGNATURE AND TITLE	DATE